THOMPSON RIVERS UNIVERSITY

IMMUNIZATION REQUIREMENTS
RESPIRATORY THERAPY PROGRAM

Note: Please complete this form and sign it before submitting. A Public Health Care Provider/Physician certification is also required to prove validity. Form is due by **AUGUST 30**. Please keep a copy for your reference.

Name: _____ _____ Maiden Name: _____
(Last) (First) (If applicable)

Date of Birth ____/____/____ Student ID#: _____ Personal Health Number_____

Date of entry to program: _____
(Month) (Year)

1. TB SKIN TEST

All students should have a **TB Skin Test** unless you are a known positive reactor or unless you have documented proof of a previous negative test result within the past 6 months, prior to commencement of the program.

TB Skin Test Date: _____ TB Read Date: _____ Result: _____ (mm)

Read By: _____
(Signature of Health Care Provider & agency stamp)

A Chest X-ray is required if the TB skin test is positive, or if there is a history of a previous positive reaction. It is the student's responsibility to provide this information to the University.

Chest x-ray Date: _____ Result: _____

Signature of Health Care Provider below indicated CXR has been read and is negative for TB.

_____ Signature of Health Care Provider

Please list all dates for immunizations in the following order: Year/Month/Day (Adult >18 years)

2. TD – Tdap TETANUS DIPHTHERIA PERTUSSIS

Primary Series - Tetanus/Diphtheria/Pertussis (3 or 4 doses) in early childhood: Yes ____ No _____

If answered yes: (received in childhood)

Date of Dose #3 or #4 (this is the last date of Primary Series) _____ (Date)

Td Booster _____ (Date) **A booster dose of tetanus** is required **every 10 years** after the primary series. This booster can be combined with other vaccines such as polio.

Name: _____ _____ **Maiden Name:** _____
(Last) **(First)** **(If applicable)**

2. TD – CONTINUED from Page 1

If answered no: (did not receive the primary series in early childhood) completion of **3 dose series** as an adult is required and include one dose of Tdap (to provide protection against pertussis):

Tdap (0 month) Dose #1: _____ (Date)

Td (1 month) Dose #2: _____ (Date)

Td (6 – 12 months after the 2nd dose) Dose #3: _____ (Date)

3. POLIO - IPV

Primary Polio Series- (3 doses) in early childhood: Yes _____ No_____

If answered yes: (received in childhood) A **ONE TIME** polio booster is required for healthcare workers.

Polio Booster: _____ (Date) **Polio booster** can be combined with other vaccines.

If answered no (did not receive the primary series in early childhood) completion of **3 dose series** as an adult is required.

Polio IPV Dose #1: _____(Date) **Polio IPV** Dose #2: _____(Date)

Polio IPV Dose #3: _____(Date)

4. MMR- MEASLES, MUMPS, RUBELLA

2 doses of MMR are recommended for all Respiratory Therapy Students.

Measles, Mumps and Rubella (**MMR**) Vaccine #1: _____ (Date)

Measles, Mumps and Rubella (**MMR**) Vaccine #2: _____ (Date)

5. VARICELLA- CHICKEN POX

If Varicella disease history or date of vaccines cannot be confirmed, then a Varicella IgG titre must be completed to determine immunity.

History of Disease: Yes _____ No_____ OR Date (if known) _____

Varicella immunity (IgG antibody) Yes_____ No____ If susceptible: Date _____

Varicella Vaccine Dose #1_____(Date) Dose #2 (6 wks after) _____(Date)

6. INFLUENZA - Annual vaccine as required Date: _____

Name: _____ _____ **Maiden Name:** _____
(Last) (First) (If applicable)

7. HEPATITIS B - HB

If necessary, the Hepatitis B series may be initiated upon entry into the RT program.
If you are 18 -19 years of age you need 3 doses (0.5mL each) given at 0, 1 and 6 months.
If you are 20 years of age and older you need 3 doses (1.0mL each) given at 0, 1 and 6 months.

You must have your blood checked for HepB immunity even if you've been immunized.

3-dose series:
Dose #1 (0 month): _____ (Date)
Dose #2 (1 month): _____ (Date)
Dose #3 (6 months): _____ (Date)

2-dose series (6th grade)
Dose #1 (0 month): _____ (Date)
Dose #2 (6 months): _____ (Date)

Hepatitis B Titres _____ (Date) Hep B immunity Yes _____ No _____

Be sure your test is for immunity, NOT active disease. They are different. Many people that have had the shots are no longer immune as the body metabolizes the injections.

8. COVID-19

Due to the variation in immunization dates within the COVID-19 vaccine roll-out, some students may receive their vaccinations before others. If you have received your COVID-19 vaccine already, please list the dates and manufacturer of vaccine administered.

Dose #1: _____ (Date) Manufacturer: _____

Dose #2: _____ (Date) Manufacturer: _____

I certify that the information reported is accurate and up-to-date.
Please keep a copy for your reference.

_____ _____ _____
(Signature of student) (Print Name) (Date)

_____
(Signature and stamp of Public Health or Physician Certification reviewing this document) (Date)

Return to: Tara Langley, Program Assistant
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